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Basis for Mental Health Program in Northern Samar

Jeanette Jumadiao-Rojo, MAN

Faculty, College of Nursing and Allied Health Sciences,
University of Eastern Philippines, Catarman, Northern Samar

ABSTRACT

This study aimed to know the profile of participant-implementer in terms of age, educational attainment, length of service, monthly income, trainings and seminars attended. It also aimed to know the profile of the participant-clientele in terms of age, educational attainment, number of years being recipient of health and wellness activities, number of sessions as recipient of psychological first aid, relationship to the service users, number of years as carers, and number of sessions as recipient of ASSIST BI. It sought to determine if there is a significant difference in the assessment of the two groups of participants in terms of context, input, process and output. Result of the study will serve as the basis for a proposed enhancement of the Mental Health Program in Northern Samar.

This study utilized the descriptive research design covering the 24 municipalities of the province of Northern Samar. It focussed on the components of mental health program: Wellness of Daily Living, Extreme Life Experiences, Mental, Neurological Disorders and Substance Abuse and other forms of addiction. The participant-implementers are mental health nurses giving services to service users in their respective rural health units, Municipal Health Officers,

The profile variable of participant implementer-mental health nurse are of young adulthood, earned appropriate degrees, served at least 5 years, earned 20,000 to 29,000 monthly and attended at least 5 seminars and trainings.

The profile variable of participant implementer-municipal health officer are of adulthood, earned appropriate degrees, served for 5years,earned 60,000 to 79,000 a month, and attended 5,16 to 20 seminars and trainings.

The profile variable of participant implementer-barangay health workers are of adulthood, attained secondary level, earned 10,000 below and attended at least 5 seminars and trainings.

In terms of the evaluation of the mental Health Program: Context evaluation, data revealed that participant implementer: Mental Health Nurses, Municipal Health Officers, and Barangay Health Workers rated it as "moderately implemented". Input Evaluation was rated as "moderately implemented" and Process evaluation "moderately implemented".

The level of Implementation of the Mental Health Program in Northern Samar is "moderately implemented".

With regards to the significant difference in the assessment of the mental health program by the participant implementers and participant clientele; the age, educational attainment, length of service, monthly income, seminars and trainings attended had no significant difference in the assessment of the extent of implementation of the mental health program.

With regards to the difference between the assessment of implementers and service users of psychological first aid, it was revealed that there is a significant difference between the mean of the implementers on managing extreme life experiences and service users of the extreme life experiences activities.

With regards to test of difference of the means in reference to the average 24 respondents considered implementers of the program, on the Mental-Neurological-Substance Use Disorder and 195 carers of the service Users of the program, on the Mental-Neurological- Substance Use disorder program, it revealed that there is significant difference between the means of the implementers of the program and carers of the service users of the MNS program.

Keywords: *Mental Health, Intervention, Implementation, Mental Health Program*

1. INTRODUCTION

The hope and success of each country depends on mental health its constituents have. However, little seemed to notice the encompassing effect of mental health to the success of the country. The issues of mental health and mental illness have been long overlooked by countries across the globe, in, globe. In fact developing countries allocate less than 1% of their Gross Domestic Product (GDP)to mental health, while others spend about 5% of their GDP(World Health Organization, 2007). In 2003, almost half (40–50%) of low- to middle-income countries did not have mental health policies and program. Given the stigma and lack of resources allocated to mental health care, World Health Organization (WHO) has encouraged mental health policy-makers to shift the responsibility to the primary care sector (WHO,2007).

Mental Illness is a condition alarming to the community yet people afflicted with the disease does not receive the necessary care they deserve to receive. Though alarming and debilitating, it is sad to note that only few of them receive proper and adequate treatment because of financial constraints or unavailable mental health services in the community level.

Mental illness as defined by the Federal Legislation is a" mental disorder that substantially interferes with one's life activities and ability to function". From the definition itself, an estimated 5.4 percent of the adult in United States (US) is affected by serious mental illness each year(USPublic Health Service,1999). By and large, 15 percent of adults and 21 percent of children ages 9 to 17 receive mental health services in any one year (Wang, Demler,&

Kessler,2002),however according to the World health organization (2007)a small number of those treated receive ample treatment.

Data revealed that an approximate of 61.6 million Americans experience mental illness in a given year or about one in 4 adults, one in 17 or about 13.6 million live with a serious mental illness such as schizophrenia, major depression or bipolar disorder (NAMI 2013).In the Philippines, 1 in 5 adult Filipinos have 'psychiatric disorders'. An estimated 88 per 100,000 Filipinos are suffering from mental illness where it ranked 3rd as leading cause of morbidity among Filipinos.

Seventeen percent 17% to 20% of the adult population have 'psychiatric disorders' and 10 to 15 % of children (aged 5 to 15) are believed to have mental problems. From the records of Eastern Visayas Regional Medical Center Tacloban City, in 2013 alone, there were 5247 patients who sought psychiatric consultation. In the first 3 months of 2014, there were 1072 patients, some had stopped regular consultation because of the devastation brought by typhoon Yolanda "Haiyan".In the record of Northern Samar Provincial Health Office Mental Health Program, the province has an increasing number of cases for mental illness. In 2014,there were 212 patients reported by Rural health units of 21 municipalities and it has increased by 36 with 248 reported cases in 2015. In 2016, it raised up to 300 cases. However, the vagrant ones are still unaccounted as they are still wandering in the streets because there is no agency nor institution responsible to take care of them .There is an active mental health program being implemented created by provincial Executive Order 08-2015.This leads to the creation of the Northern Samar Mental Health and Psychosocial Support Committee(MHPSC).

There is a provincial coordinator assigned who is a nurse and municipal mental health coordinators, who are nurses and are also serving the barangay.

Finally, on June 21, 2018, the Mental Health Act of 2017 was signed by Pres. Rodrigo R. Duterte affirming the basic right of all Filipinos to mental health as well as the fundamental rights of people who require mental health services. An assessment of the previous Mental Health Program as implemented in the province of Northern Samar which can provide inputs for the next activities or strategies for implementation is deemed necessary, thus this study.

2. Statement of the Problem

Generally, the study sought to determine the extent of implementation of the Mental Health Program in Northern Samar which served as a basis for an enhancement program which can be proposed as an output of the study.

Specifically, it sought to find out answers to the following:

1. What is the profile of participant-implementers and participant-clientele?

1.1. mental health nurses in terms of:
1.1.1. Age
1.1.2. educational attainment
1.1.3. length of service
1.1.4. monthly income
1.1.5. trainings/seminars attended

1.2. Municipal health officers in terms of:
1.2.1. Age
1.2.2. educational attainment
1.2.3. length of service
1.2.4. monthly income
1.2.5. trainings/seminars attended

2. Is there a significant difference in the assessment of the participants on the extent of implementation of the Mental Health Program when participants are grouped according to the profile variables in terms of the following?

2.1. Context
2.2. Input
2.3. Process
2.4. Product

3. What suggestions/recommendations are provided by the two groups of participants?

3. METHODOLOGY

Research Design

This study utilized the descriptive design. According to Burns and Groove (2003), descriptive research is intended to provide a picture of the situation as it naturally happens." For the purpose of this study, descriptive research was utilized to determine the extent of implementation of the mental health program. It covered the Context, Input, Process, and Product evaluation of the Mental Health Program of Northern Samar.

Data presents the frequency and percentage distribution of Mental Health Nurses' Age. It presents that majority of the total 24 nurses-implementers, with 16 or 67 percent belong to the age range 18 to 39 years old and the rest, 8 or 33 percent belong to the age range 40 to 65 years old. This information revealed that most nurses involved in the study are in young adulthood. Research shows that that those belonging to this age group are considered mellineals which increasingly dominate the health care workplace. This group are setting new standards for excellence in the profession. Their positive characteristics are advantageous in to the profession-they are self-confident and believe they contribute value to the workforce. They are change agents. What this creates is an employee who is more than willing to engage and learn new task in order to help the mentally ill individuals in the community.

Data presents the frequency and percentage distribution of mental health nurses' educational attainment. Among them, 24 or 100 percent finished Baccalaureate degree. Regardless of where a mental health nurse works, education is usually part of the job description. The first step is graduating from an accredited registered nursing program. The Bachelor of Science in Nursing is the entry for nursing practice in the community setting. The first step to becoming a psychiatric nurse practitioner is obtaining a bachelor's degree, which generally takes four years of full-time study. Bachelor of Science in Nursing is a four-year degree program in the Philippines that revolves around caring for the sick or injured. This does not only involve addressing immediate threats to the patient's health, but also guiding the patient all the way through physical, mental and emotional recovery.

The data presents the frequency and percentage distribution of the mental health nurses' length of service. It shows that 13 or 54 percent implementer-participant nurses indicated they had been employed as nurses 5 years ago; 7 or 29.1 percent with seven (7) years in the service and the rest, 4 or 16.7 percent with 6 years' experience in nursing job. According to Benner Benner's Stages of Clinical Competence, in the acquisition and development of a skill, a nurse passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert.

Data implies that generally the nurses belong to stage 3: within a level possessing competence in his job. Competence is demonstrated by the nurse who has been on the job in the same or similar situations for two or three years. The nurse is able to demonstrate efficiency, is coordinated and has confidence in his/her actions. For the Competent nurse, a plan establishes a perspective, and the plan is based on considerable conscious, abstract, analytic contemplation of the problem. The conscious, deliberate planning that is characteristic of this skill level helps achieve efficiency and organization. Care is completed within a suitable time frame without supporting cues. Benner, P.(1984)

It has been shown that the length of service was related to continuance commitment and occupational commitment. Also, pre-retirement of the nurses after 20 years of work can result in an increase in average commitment of the nurses. The possible limitations were the effect of social desirability that existed on the part of employees.

The study presents the frequency and percentage distribution mental health nurses' monthly income. It notes that majority, 17 or 70 percent had a monthly income of ranging from 20,000to 29,999 and only 5 out 24 total respondent-nurses were receiving ranging from 30,000 to 39,000 and the rest, 2 or 8.4 percent were receiving within the range under l0,000 to 19,999. This would imply the salary of nurses is at least already above poverty line. Psychiatric nurse salaries depend on the level of education, years of experience, size of employer, and where you live and work. In May 2016, the Bureau of Labor Statistics reported the range for RN salaries as $47,120 to $102,990. The mean annual income for a nurse working in the psychiatric or substance abuse hospital setting was $69,460.

According to the Department of Budget and Management, the adjusted compensation for teachers and nurses ranges from P20, 754, which is the entry pay, to P22,829.

The study presents the frequency and percentage distribution of the mental health nurses according to relevant trainings and seminars attended. It was noted that l2 out of 24 respondent-nurses or 50 percent had attended trainings/ seminars from 6 to l0 times; ll or 45.8 percent had at least attended 5 times and only l of them or 4.2 percent was able to attend more than 11 times. According to (Aiken et al, 2003), Appropriate training of nurses is vital in order to ensure high quality and safety in patient care.

In 2005, the Professional Regulatory Board of Nursing (PRBON) Resolution no. 112 Series of 2005 adopted and promulgated the Core Competency Standards of Nursing Practice in the Philippines. As mandated, the Professional Regulatory Board of Nursing ensured, through a monitoring and evaluation scheme, that the core competency standards were implemented and utilized effectively in nursing education, in the development of test questions for the Nurse Licensure Examination (NLE), and in nursing service as a basis for orientation, training and performance appraisal. Through the years of implementation, global and local developments in health and professional nursing prompted the PRBON to conduct a "revisiting" of the Core Competency Standards of Nursing Practice in the Philippines. In 2009, the PRBON created the Task force on Nursing Core Competencies Revisiting Project in collaboration with the Commission on Higher Education - Technical Committee on Nursing Education and selected nursing leaders from the various nursing professional organizations with the primary goal of determining the relevance of the current nursing core competencies to expected roles of the nurse and to its current and future work setting.

Table 57 reveals the test of difference on educational attainment of implementer participants in terms of Process. Result of the analysis applying F-tests between – subjects effects of Education on implementer participants revealed that, it is impossible to construct the pairwise comparison table because Nurse education, as a factor being compared has one level, that means only referred to a baccalaureate degree only.

Based on the data about the Education of Municipal Health Officer, the mean square of .003 with F-ratio of .017 at P-value of .899 and the clientele participants, the Barangay Health Workers, its mean square of .020 with F-value of .i03 at P-value level of significance .751 are large enough to reject the alternative hypothesis at .05 level of significance.

Based on the information indicated above, it is obvious that the null hypothesis, that there is no significant difference of the mean squares among implementer participants and clientele participantss on education is accepted and the alternative hypothesis is rejected, based on the principle of rejection, that if the P-value is greater than the margin of error at .05 Alpha level of significance, the null hypothesis has to be accepted and the alternative should be rejected. This further asserts that, there is no significant difference on the assessment of extent of implementation of the mental health program by the implementer participants in terms of educational attainment.

Table 58 reveals the test of difference on length of service of implementer participants in terms of Process. Result of the analysis applying F-tests between – subjects effects of Length of Service, on implementer participants revealed that, based on the information Nurses, has a mean square of .012 with F-ratio of .054 at F-probability level of .947; the Municipal Health Officer, has the mean square .130 with F-value .605 at F-probability level of significance .558 and the clientele participants, the Barangay Health Worker, has its mean square of .122 with F-ratio of .568 at F-probability level of significance .644 are large enough to reject the alternative hypothesis at .05 Alpha level of significance.

Based on the information indicated above, it is obvious that the null hypothesis, that there is no significant difference of the mean squares among implementer participants on the Length of Service is accepted and the alternative hypothesis is rejected, based on the principle of rejection, that if the F-probability value is greater than the margin of error at .05 Alpha level of significance, the null hypothesis has to be accepted and the alternative should be rejected. This further asserts that, there is no significant difference on the assessment of extent of implementation of the mental health program by the implementer participants in terms of length of service.

Table 59 reveals the test of difference on monthly income of implementer participants in terms of Process. Result of the analysis applying F-tests between – subjects effects of Income, in the process of the implementation of Mental Health Program on implementer participants revealed that, based on the information Nurses, has a mean square of .178 with F-ratio of 1.112 at F-probability level of ..370; the Municipal Health Officer, has the mean square .183 with F-value 1.147 at F-probability level of significance .298 and the clientele participants, the Barangay Health Workers, has its

mean square of .334 with F-ratio of 2.091 at F-probability level of significance .165 are large enough to reject the alternative hypothesis at .05 Alpha level of significance.

Based on the information reflected above, it is obvious that the null hypothesis, that there is no significant difference of the mean squares acquired among implementer participants on the monthly income is accepted and the alternative hypothesis is rejected, based on the principle of rejection, that if the F-probability value is greater than the margin of error at .05 Alpha level of significance, the null hypothesis has to be accepted and the alternative should be rejected. This further asserts that, there is no significant difference on the assessment of extent of implementation of the mental health program by the implementer participants in terms of monthly income.

Table 60 shows the Test of Difference on seminars and trainings attended by implementer participants in terms of Process. Result of the analysis applying F-tests between – subjects effects of Seminar & Training attended, as factor to improve the process of Mental Health Program development by the implementer participants revealed that, based on the information indicated Nurses has a mean square of .039 with F-ratio of .227 at P-value level of .800; the Municipal Health Officer, has the mean square .249 with F-value 1.443 at P-value level of significance .263 are large enough to reject the alternative hypothesis at .05 Alpha level of significance.

Based on the information shown above, it is obvious that the null hypothesis, that there is no significant difference of the mean squares among implementer participants on their seminars and trainings attended is accepted and the alternative hypothesis is rejected, based on the principle of rejection, that if the P- value is greater than the margin of error at .05 Alpha level of significance, the null hypothesis has to be accepted and the alternative should be rejected. This further asserts that, there is no significant difference on the assessment of extent of implementation of the mental health program by the implementer participants in terms of seminars and training attended.

Table 62 shows the test of difference of mean between the participant implementer on wellness program and service users of wellness program.

Result of the analysis using t-test revealed that, based on the responses of average 24 respondent-implementers on extreme life circumstances wellness program, the mean was 3.40 with t-value 52.69 at t-probability level, .000, and as to the mean of 150 individual respondent-service users of the wellness program with t-value, 17.60 at t-probability level, .000.

Based on the indicated information given above, the null hypothesis that, there is no significant difference of the means among implementers of wellness program and the 150 service users of the wellness program was rejected.

In reference, to the principle of rejection that if the t-probability level is lesser than the margin of error, at .05 Alpha level of significance, the null hypothesis is to be rejected and the alternative should be accepted, that there is a significant difference between the mean of the implementers on wellness program and service users of the wellness program.

Suggestions/Recommendations Provided by the Two Groups of Participants

1. Make a comprehensive plan for mental health program with specific goals and objectives that are attainable.
2. Increase collaboration between Local Government Units and Rural health unit to increase fund allocation for the medications and facilities. Create a stronger LGU support on the Mental health program.
3. Mental health should be prioritized. Formulation of health activity for mental health promotion, Physical activities promotion including sports/cultural activity livelihood programs. Create more activities to promote mental health of patients including well clients.
4. Fund allocation for mental health medications
5. Monthly meeting and assessment of needs and resources of patients.
6. Create a mental health core team. Assign a team for mental health program who will provide assistance to the patient and family.
7. Create support groups/counsellors
8. Increase surveillance so that more case findings for Mental Health patients
9. Increase cure rate by provision of effective psychotherapies
10. Conduct training s and workshops to health personnel .More trainings and workshop for the health staff including the Municipal Health Officers to improve their expertise on handling mental cases with especial consideration to those that are GIDA (Geographically disadvantaged area)municipalities
11. Upgrade the facilities for it to be able to provide the needs of mentally challenged patients with sub acute cases, with a sustainable psychotropic medications.
12. There should be specific health personnel from Department of health to handle the program.
13. Hiring of adequate nurses for mental health program for a much focused and tailored fit services.
14. Create an active wellness and mental health program to improve lives of clients
15. Create a low cost rehabilitation center here in the province

4. Conclusion

In light of the findings of the study, the following conclusions and implications were drawn:

1.1 Majority of implementer participant -mental health nurses are of young adulthood, earned appropriate degrees, served at least 5 years, earned 20,000 to 29,000 monthly and attended at least 5 seminars and trainings.

1.2 Majority of implementer participant -municipal health officer are of adulthood, earned appropriate degrees, served for 5years,earned 60,000 to 79,000 a month, and attended 5,16 to 20 seminars and trainings.

1.3 Majority of implementer participant -barangay health workers are of adulthood, attained secondary level, earned 10,000 below and attended at least 5 seminars and trainings.

1.4 Majority of participants of health and wellness program are of adulthood, earned baccalaureate degree, recipients of health and wellness activities within 0 to 5 months.

1.5 Majority of clientele participants-service users of psychological first aid are of young adulthood, reached secondary level, with 1 to 2 sessions as recipient of its activities.

1.6 Majority of clientele participants-carers of service users with Mental and Neurological and substance abuse Disorder are of adulthood, mostly mothers, served their sons/daughters within 5 years.

1.7 Majority of clientele participant -recipient of ASSIST BI are of young adulthood, reached secondary level with 1 to 2 sessions attended and have been drug users for 1 year.

2. The activities on mental health and wellness program: Wellness of Daily Living, data shows that the implementer participants rated it as "moderately implemented" while the clientele participants rated it as "less implemented".

In the activities of implementation of management of extreme life experiences, data revealed that the participant-implementer rated the program as "highly implemented" while clientele participants rated it as "highly implemented".

As to the implementation of management of Mental, Neurological and Substance Abuse Disorder, data revealed that implementer participants evaluated the program as "highly implemented", while the clientele participants evaluated the program as "highly implemented".

With regards to the implementation of management Drug Abuse, and other forms of Addiction the participant implementer rated it as "moderately implemented", while the clientele participants assessed the program as "moderately implemented".

In terms of Product data revealed that the level of Implementation of the Mental Health Program in Northern Samar is "moderately implemented".

In terms of the significant difference in the assessment of the participants on the extent of implementation of the mental health program, Context evaluation; data revealed that implementer participants' age, educational attainment, length of service, monthly income, seminars and trainings attended has no significant difference in their assessment on the extent of implementation. In relation to Input Evaluation, the age, educational attainment, length of service, monthly income, seminars and trainings attended has no significant difference in their assessment on the extent of implementation, and in Process evaluation, the age, educational attainment, length of service, monthly income, seminars and trainings attended has no significant difference in their assessment on the extent of implementation of the mental health program.

It was suggested and recommended by the implementer participants and clientele participants to make a comprehensive plan for mental health program with specific goals and objectives that are attainable, increase collaboration between Local Government Units and Rural health unit to increase fund allocation for the medications and facilities, Create a stronger LGU support on the Mental health program. It was also suggested that mental health should be prioritized. Formulation of health activity for mental health promotion.

Furthermore, it was also suggested to increase fund allocation for mental health medications, plan monthly meeting and assessment of needs and resources of patients, create a mental health core team and create support groups/counsellors.

5. Recommendations

1. More meetings intended to look into the outcomes of the implementation of the mental health program.
2. Create a mental health plan tailored fit to provide quality mental health services for the mentally incapacitated individuals through the efforts and strong commitment of the leaders.
3. Strengthen the collaboration between the Local Government Unit and the Rural health Units through a strong leadership paralleled by a strong political will to increase funding and support to the mental health program. It will also increase the chances for an up to date provision of psychotrophic medications making its supply uninterrupted, including consistent availability of side reaction medications.
4. Municipal Health Officers need to have an update through relevant trainings and seminars to improve the quality in the delivery of mental health services.
5. Increase the number of staff trained to provide an expert service for the conduct of its activities and psychotherapies. Continuous support and training of staff/health care professional to increase sustainability of the program.
6. Provide support services to the carers of mentally challenged individuals.
7. Increase community awareness through intensified information drive and health education to increase awareness and understanding amongst families with mental illness and community and decrease social stigma, discrimination and abuse.

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